Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Friday, March 15, 2019 at the hour of 9:00 A.M. at 1950 W. Polk Street, in Conference Room 5301, Chicago, Illinois.

I. Attendance/Call to Order

Acting Chair Koetting called the meeting to order.

Present: Acting Chair Mike Koetting and Directors Hon. Dr. Dennis Deer, LCPC, CCFC; Ada Mary Gugenheim; and Robert G. Reiter, Jr. (4)

Directors Mary B. Richardson-Lowry and Sidney A. Thomas, MSW (Substitute Members)

Telephonically Present: Board Chair M. Hill Hammock (1) and Gerald Bauman (Non-Director Member)

Absent: Director Layla P. Suleiman Gonzalez, PhD, JD (1)

Director Gugenheim, seconded by Director Thomas, moved to allow Board Chair Hammock to telephonically participate in the meeting as a voting member. THE MOTION CARRIED UNANIMOUSLY.

Additional attendees and/or presenters were:

Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Debra Carey – Deputy Chief Executive Officer, Operations
Elizabeth Festa – CountyCare Compliance Officer
Jeff McCutchan –General Counsel
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit
John Jay Shannon, MD – Chief Executive Officer
Dianne Willard – CCHHS Compliance Officer

II. Public Speakers

Acting Chair Koetting asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from Chief Corporate Compliance and Privacy Officer (Attachment #1)

- **Annual Report - Cook County Health as a Provider of Health Care Services**
- **Annual Report – CountyCare Medicaid Health Plan**

Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, provided an overview of the information contained in the Report. Dianne Willard, CCHHS Compliance Officer, and Elizabeth Festa, CountyCare Compliance Officer, provided additional information. The Committee reviewed and discussed the information.

III. Report from Chief Corporate Compliance and Privacy Officer (continued)

The report included information on the following subjects:

- Background and Metrics
- Organizational Chart
- Year-Over-Year Comparison
- Metrics/Annual Reports:
  - Cook County Health as a Provider of Health Care Services
  - CountyCare Medicaid Health Plan

IV. Action Items

A. Minutes of the Audit and Compliance Committee Meeting, November 15, 2018

Director Reiter, seconded by Director Gugenheim, moved to accept the minutes of the Audit and Compliance Committee Meeting of November 15, 2018. THE MOTION CARRIED UNANIMOUSLY.

B. Review and approve Internal Audit Charter (Attachment #2)

Tom Schroeder, Director of Internal Audit, provided an overview of the Internal Audit Charter. He indicated that he is proposing only cosmetic changes to the Charter to update it, including changing references of CCHHS to reflect the recent change to "Cook County Health."

Director Suleiman Gonzalez, seconded by Director Gugenheim, moved to approve the proposed changes to the Internal Audit Charter. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections IV and V

V. Closed Meeting Items

A. Report from Director of Internal Audit
B. Discussion of Personnel Matters

Director Reiter, seconded by Director Gugenheim, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and 5 ILCS 120/2(c)(**29**), regarding "meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America."

V. Closed Meeting Items (continued)

On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

Yeas: Acting Chair Koetting, Board Chair Hammock and Directors Deer, Gugenheim and Reiter (5)

Nays: None (0)

Absent: Director Suleiman Gonzalez (1)

THE MOTION CARRIED UNANIMOUSLY and the Committee convened into a closed meeting.

Acting Chair Koetting declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VI. Adjourn

As the agenda was exhausted, Acting Chair Koetting declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
Mike Koetting, Acting Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

There were no requests for follow-up at this meeting.

ATTACHMENT #1

Corporate Compliance Report

Audit & Compliance Committee of the Board of Directors

March 15, 2019

COOK COUNTY HEALTH

Meeting Objectives

Review

Background & Metrics

- Organizational Chart
- Year-Over-Year Comparison
- Metrics
  - Cook County Health as a Provider of Health Care Services
    - Provider Annual Report
  - CountyCare Medicaid Health Plan
    - CountyCare Annual Report

Action

- Annual Education (4-Required Modules)

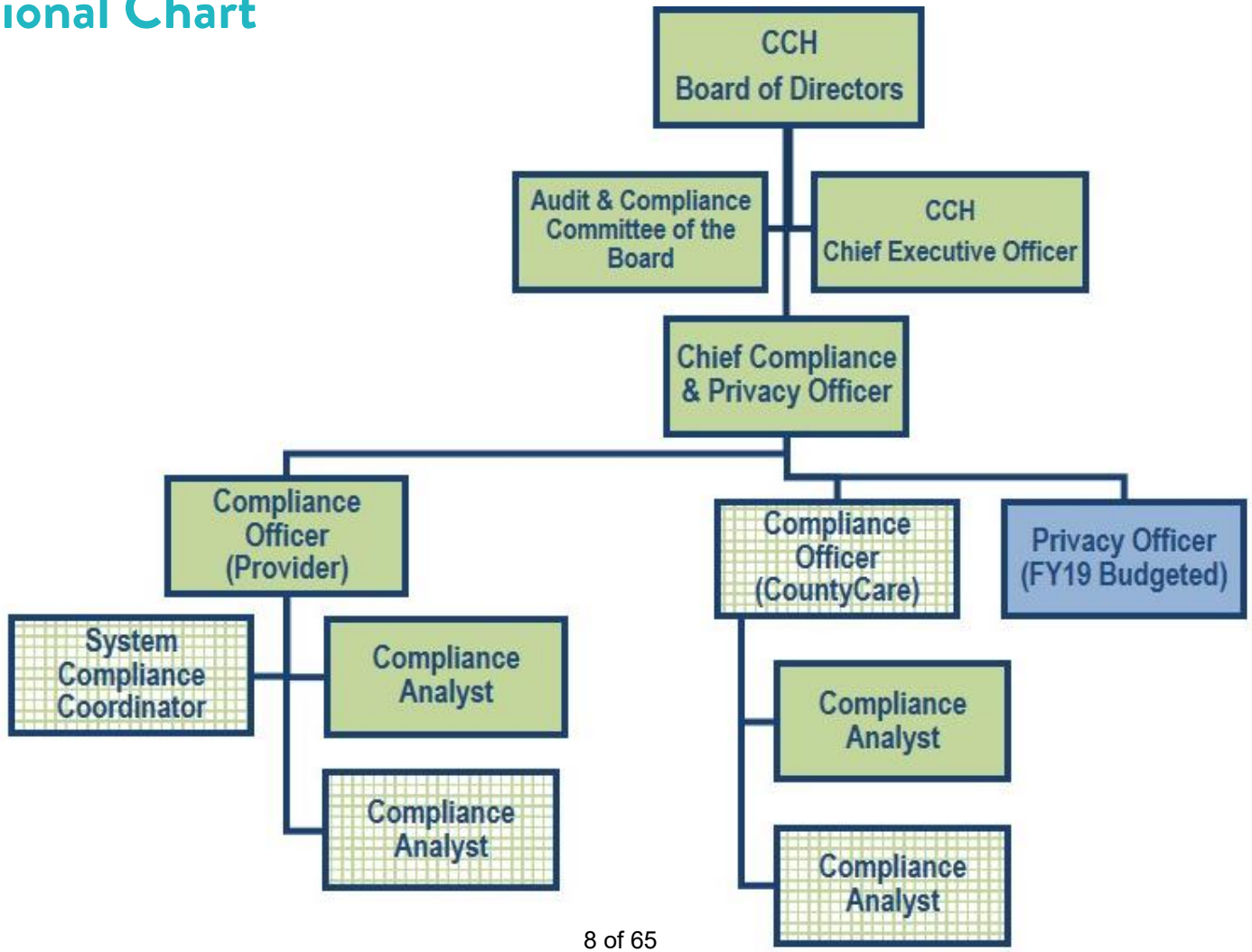
Corporate Compliance

Background

COOK COUNTY HEALTH

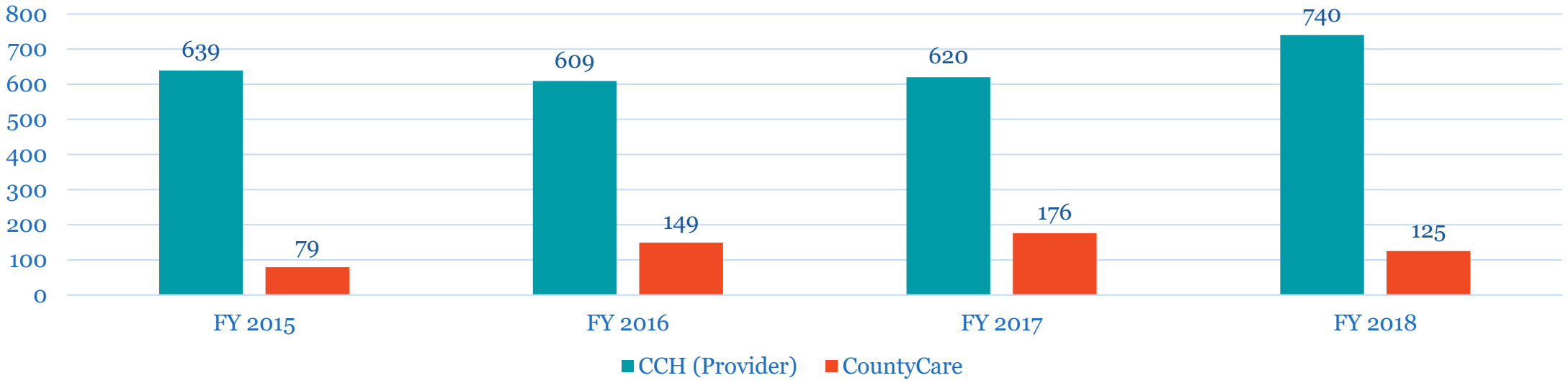
CCH Corporate Compliance Staffing

2018 Organizational Chart



Year-Over-Year Contacts

Separating out CCH as a Provider of Care and as the CountyCare Health Plan



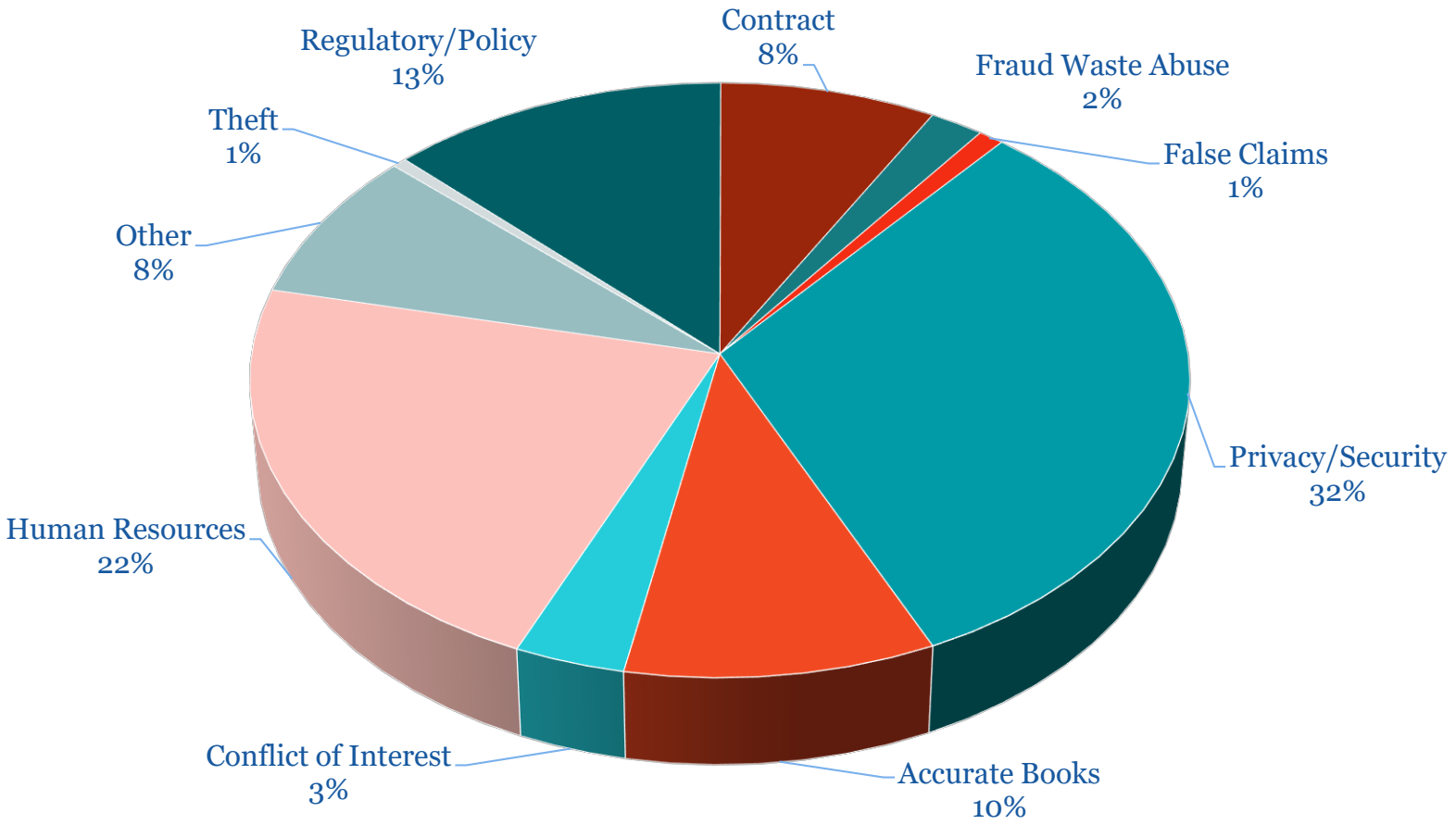
Metrics

Cook County Health as a Provider of Care

COOK COUNTY HEALTH

2018 Contacts by Category

CCH as a Provider of Care

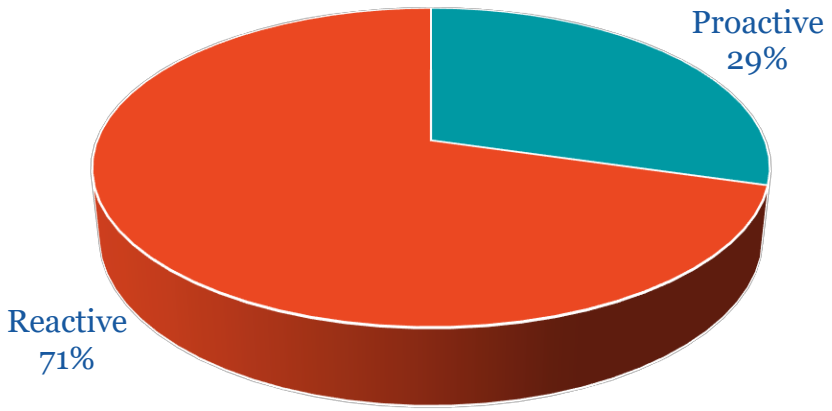


Categories	
Privacy/Security (HIPAA)	237
Human Resources	163
Regulatory/Policy	94
Accurate Books	73
Contracts	60
Conflict of Interest	26
Fraud Waste & Abuse	15
False Claims	7
Theft	4
Other	61
	740

2018 Proactive vs. Reactive Activity

CCH as a Provider of Care

- Reactive activities are unanticipated contacts, queries, or concerns.
- Proactive activities anticipate possible issues.

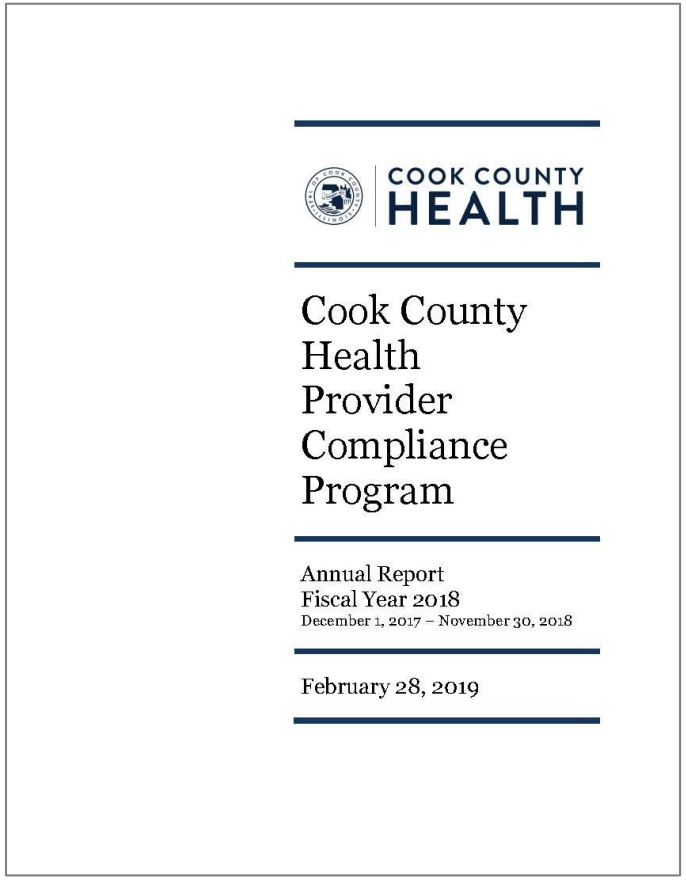


While proactive activity is optimal, reactive activity is not viewed negatively by Corporate Compliance. A majority of reactive contacts indicate awareness of the Compliance Program as an organizational resource.

COOK COUNTY HEALTH

Annual Report

CCH as a Provider of Care

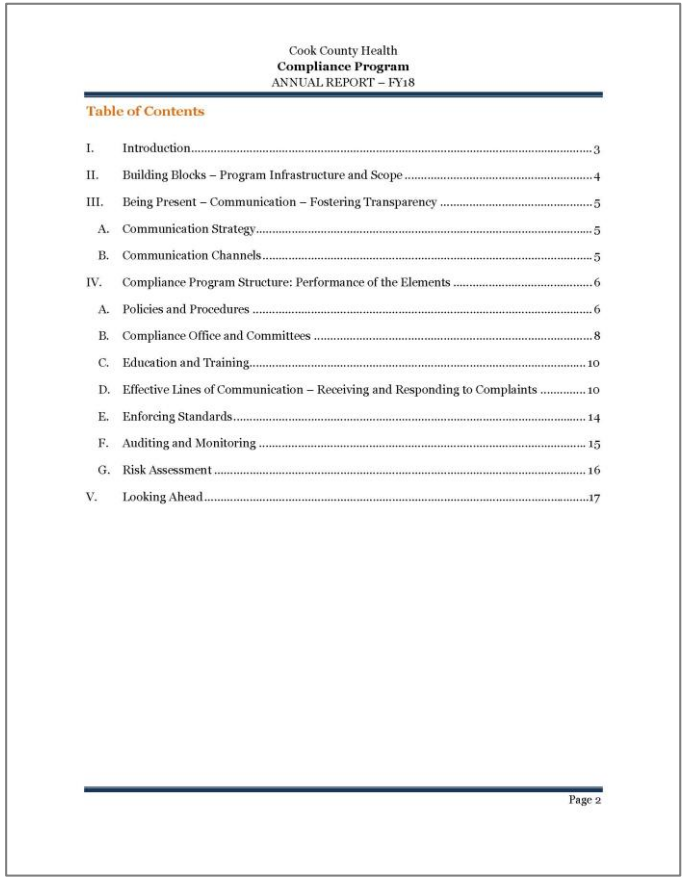


COOK COUNTY HEALTH

Cook County Health Provider Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019



Cook County Health
Compliance Program
ANNUAL REPORT – FY18

Table of Contents

Page 2

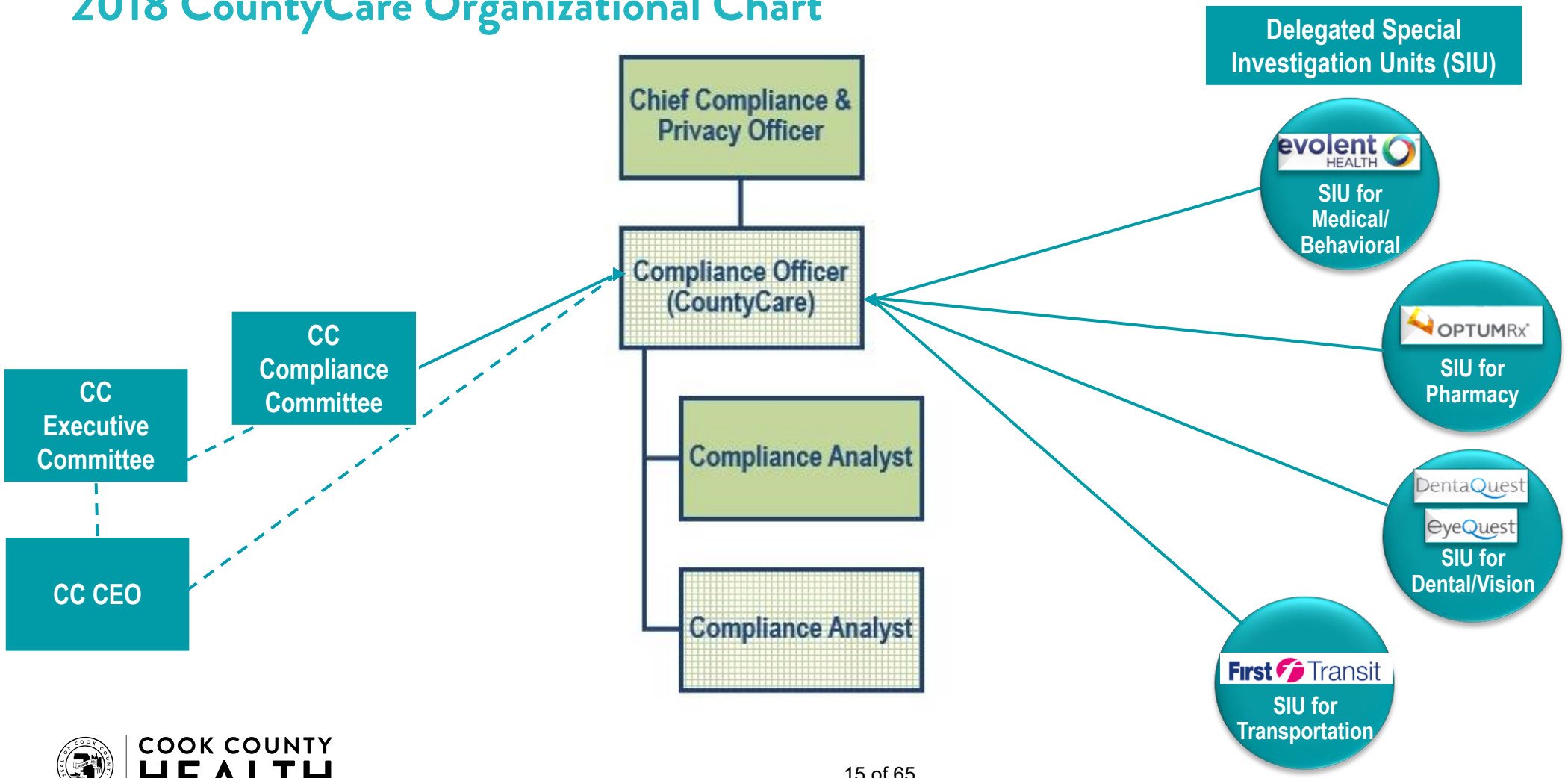
Metrics

CountyCare Health Plan

COOK COUNTY HEALTH

CCH Corporate Compliance Staffing

2018 CountyCare Organizational Chart



Fraud, Waste and Abuse Metrics

State Fiscal Year (S-FY) 2018 through S-FY19 Q1

S-FY	Reporting Quarter	Tips	Preliminary Investigations	Full Investigations	Referrals to HFS OIG	Provider Audits	Overpayments Identified *2	Overpayments Collected
18	Q1 07/01 -09/30/17	1	11	3	3	3	$ 97,910.84	$ 2,574.00
18	Q2 10/01 – 12/31/17	2	8	9	1	1	$ 201,038.64	$ 2,961.36
18	Q3 01/01 – 03/31/18 *1	70	5	15	2	103	$ 457,245.29	$ 6,097.85
18	Q4 04/01 – 06/30/18	6	5	9	2	57	$2,305.959.74	$ 28,216.99
19	Q1 07/01 -09/30/18	15	34	11	0	173	$ 694,801.54	$ 44,385.25

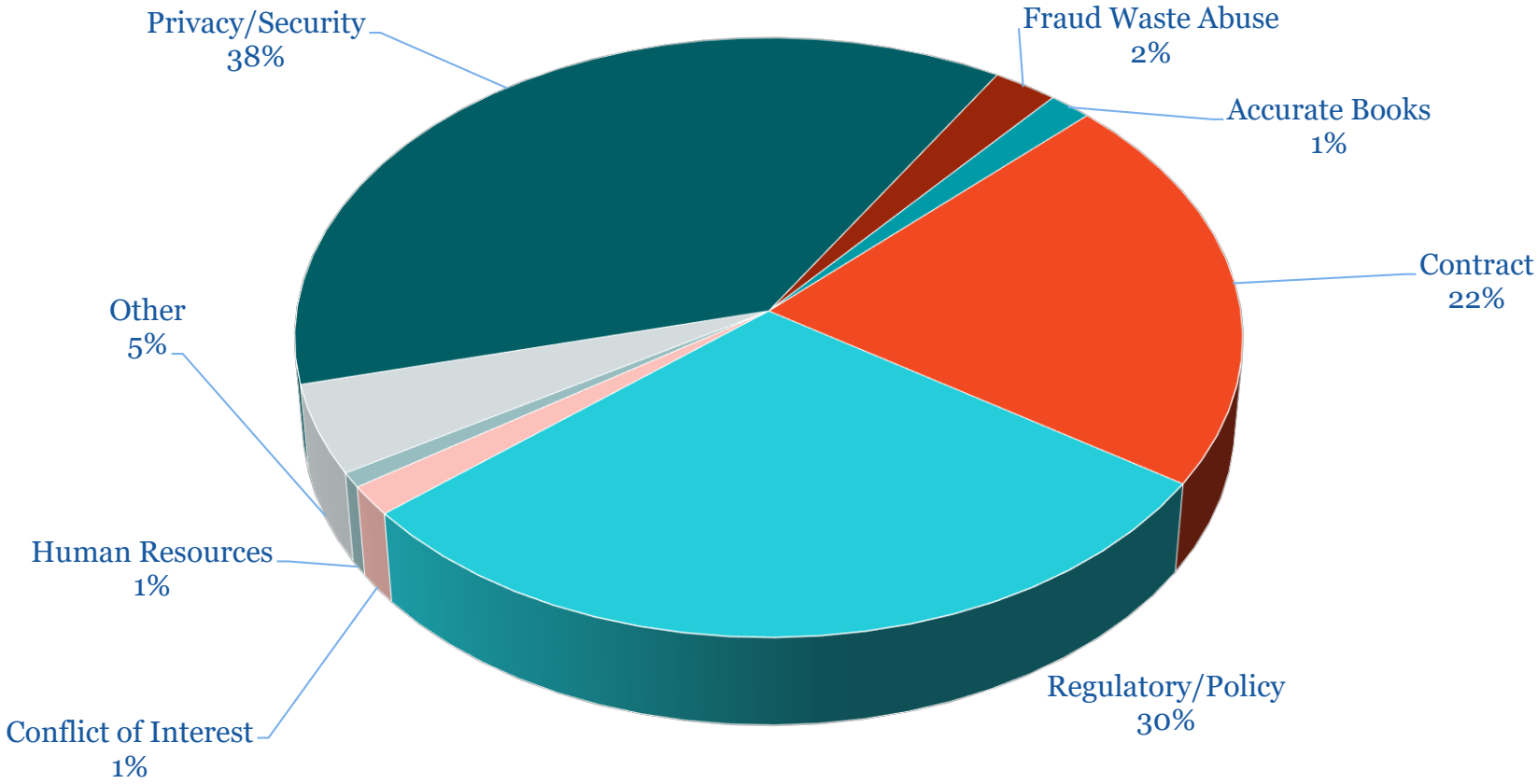
*1 The 3rd Quarter S-FY 18 was significant for CountyCare Compliance. Evolent, CountyCare's TPA for medical and behavioral health hired two (2) local investigators dedicated solely to program integrity efforts. This dedicated team partnered with a data analytics firm to review claims for anomalies. The result of this activity is apparent in the metrics above.

*2 The Overpayments Identified column indicates the total amount paid to the provider for the identified inaccurate codes. These amounts may be offset if a provider elects to bill a corrected claim.

Example: The highest level clinic visit is billed to the health plan, reimbursement is $48, the medical record is reviewed and the documentation validates a lower level. The "Overpayment Identified" is $48, however the provider may rebill a lower level and expect corresponding reimbursement of $28.35. This category does not account for the net recovery of $19.65.

2018 Contacts by Category

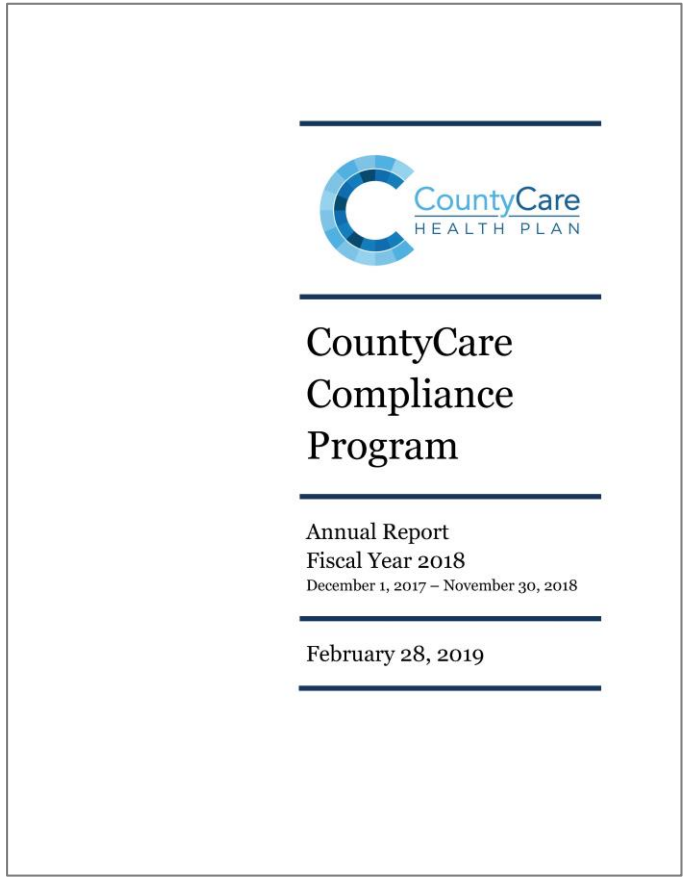
CountyCare Health Plan



Categories	
Privacy/Security (HIPAA)	47
Regulatory/Policy	37
Contracts	27
Fraud Waste & Abuse	3
Conflict of Interest	2
Accurate Books & Records	2
Human Resources	1
Other	6
	125

Annual Reports

CountyCare Health Plan

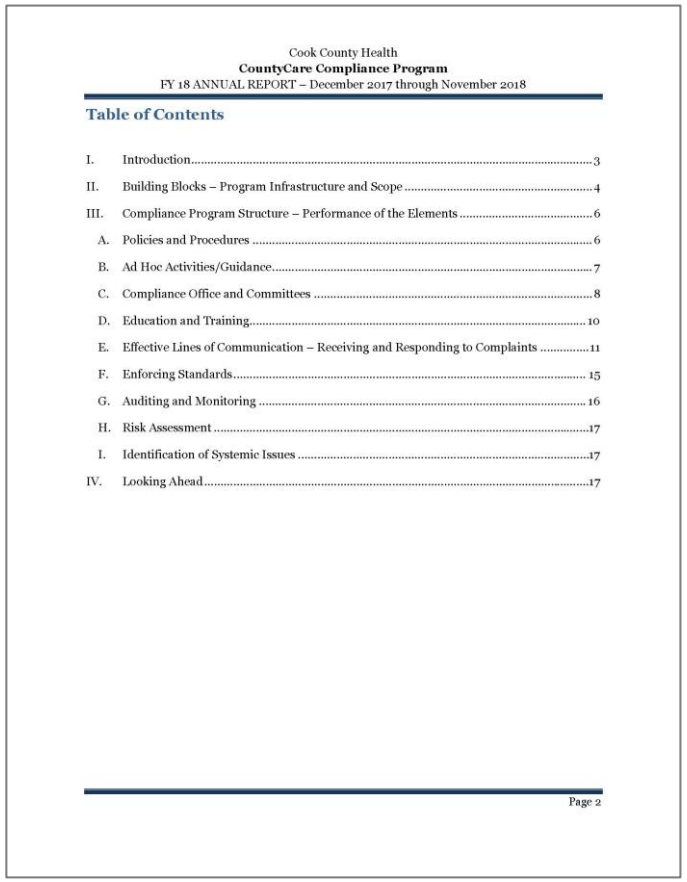


CountyCare HEALTH PLAN

CountyCare Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019



Cook County Health
CountyCare Compliance Program
FY 18 ANNUAL REPORT – December 2017 through November 2018

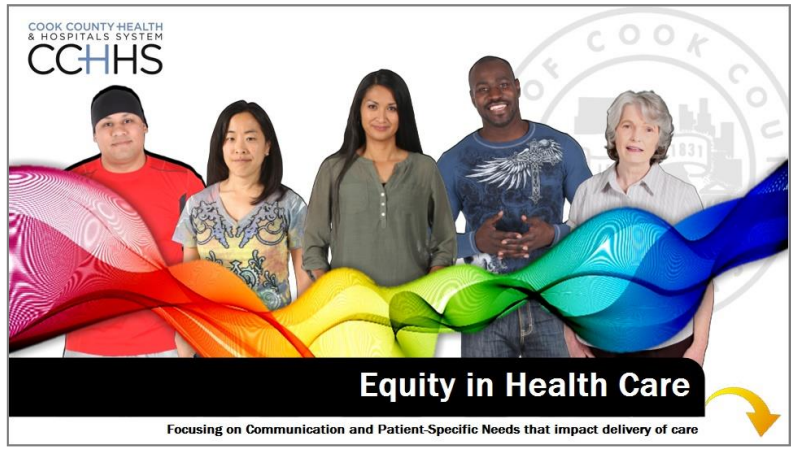
Table of Contents

Page 2

Annual Education

COOK COUNTY HEALTH

Annual Requirement



Questions?

COOK COUNTY HEALTH

COOK COUNTY HEALTH

Cook County Health Provider Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019

Table of Contents

I. Introduction

Cook County Health (CCH) Corporate Compliance incorporates two (2) distinct Compliance Programs: CCH as a provider of health care services and the CountyCare Medicaid Health Plan. Provider services occur within both CCH hospitals (John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County), multiple outpatient clinics, correctional medicine at the Cook County Jail and Juvenile Temporary Detention Center, and the Cook County Department of Public Health. It also includes physicians and others that provide direct care to patients, and workforce members not directly involved in patient care. Although the CountyCare Medicaid Health Plan's Compliance Program is addressed through a separate annual report, both programs function at the system level and are committed to the mission of Cook County Heath:

> *"To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well-being of the people of Cook County."*

Corporate Compliance supports CCH's Mission through a departmental Mission updated and approved by the Audit and Compliance Committee of the Board of Directors on September 20, 2018. The mission reads,

> *"The Corporate Compliance Program upholds the mission, vision, and core values of Cook County Health by:*
> - *Developing standards to guide everyone affiliated with CCH to "Do the Right Thing"*
> - *Increasing compliance awareness through education and training*
> - *Promoting collaboration, honest behavior, mutual respect, and professional responsibility*
>
> *to support compliance with applicable laws, regulations, and system-wide policies."*

Corporate Compliance similarly updated the Compliance Vision statement:

> *"To ensure safeguards are in place for our patients, health plan members, health plan providers, the residents of the county of Cook, and our workforce members, staff, and the public at large, the Corporate Compliance Program will be a resource to everyone affiliated with and cared for by Cook County Health."*
>
> *(For the purposes of this statement, "affiliated" is defined as all patients, health plan members, health plan providers, the residents of the county of Cook, and workforce members that include employees, medical staff, house staff, Board members, volunteers, students, partners, consultants, agency personnel, and vendors.)*

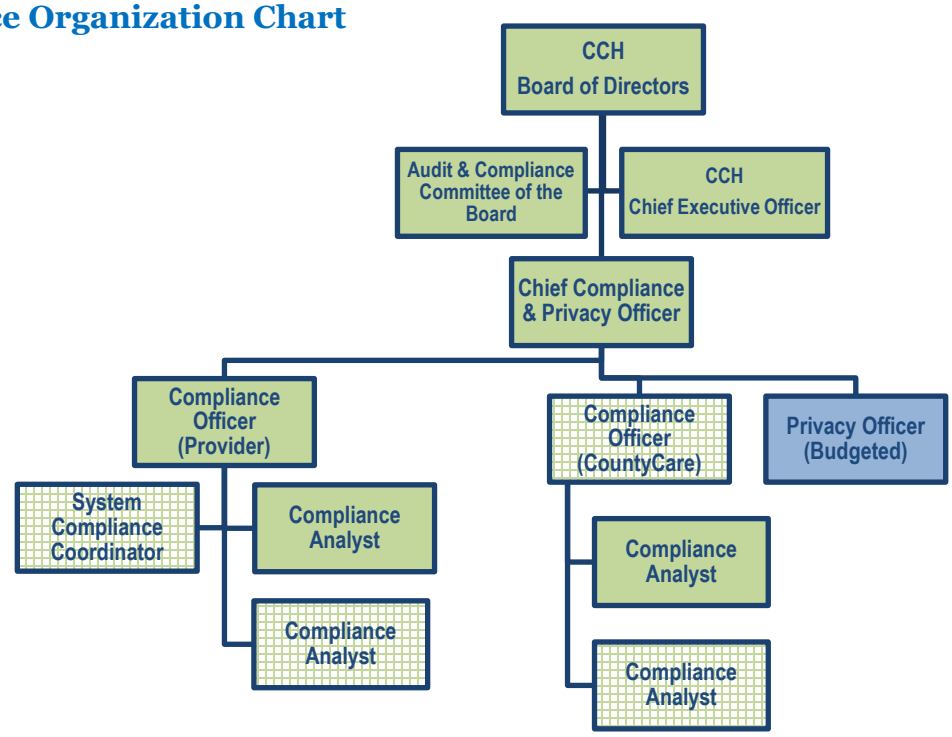
This Annual Report presents the activities throughout County fiscal year 2018 of the CCH Provider Corporate Compliance Program under the executive leadership of Cathy Bodnar, Chief Compliance and Privacy Officer, and the operational leadership of Dianne Willard, Compliance Officer. This report also serves to demonstrate the effectiveness of the compliance program by

looking at infrastructure, communication strategy and channels. In addition, this report provides an assessment of the CCH Provider Compliance Program by using the seven (7) Compliance Program Elements of a comprehensive compliance program delineated by the Office of Inspector General (OIG).

II. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the activities of the Program that incorporate efforts to foster an infrastructure that produces a comprehensive compliance program. The existing Departmental Organization Chart follows:

Compliance Organization Chart



The lightly shaded positions indicate the new hires within FY18. Four (4) of the 7-positions within Corporate Compliance were filled within the fiscal year, including the Compliance Officer assigned to CountyCare. Although this placed a significant strain on the existing resources, the performance by the existing team members was noteworthy. Management of the core elements of the Program continued while an individualized development plan for each new team member was undertaken. This was critical to the success of each individual and the Program overall.

Corporate Compliance Program Scope

Cook County Health activities that fall into the Corporate Compliance purview are:

- Interpretation of laws, rules, and regulations and organizational policy as they relate to Corporate Compliance;

- Accurate Books and Records;
- Anti-kickback Activities;
- Conflict of Interest;
- Emergency Medical Treatment and Labor Act (EMTALA);
- False Claims;
- Financial Integrity;
- Fraud, Waste, and Abuse;
- Integrity in both Marketing and Purchasing Practices;
- Patient Privacy, Confidentiality, and Security (HIPAA);
- Research, Clinical Trials, and Grant Compliance; and
- Undue Political Activity/ Operational Influence.

III. Being Present – Communication – Fostering Transparency

A. Communication Strategy

The ongoing organizational compliance communication strategy has been to increase the CCH workforce awareness of the following topics:

- Code of Ethics;
- Privacy, Confidentiality, and Security;
- Accessibility of the Compliance Officer and the compliance team;
- Availability through multiple modalities;
- Responsibility to report potential/actual issues; and
- Non-retaliation.

B. Communication Channels

Within FY18, the Corporate Compliance Program communicated the aforementioned topics utilizing multiple formats:

- E-mail communications;
- Organizational newsletters (System Briefs);
- Record Retention guidance;
- Annual education;
- Screen savers;
- Attendance/presence at team meetings;
- Compliance Program business cards;
- Pens with the compliance hot line number;
- Privacy Protector wrist bands;
- Code of Ethics posters; and
- Dual employment and conflict of interest reporting.

IV. Compliance Program Structure: Performance of the Elements

Element 1

The development and distribution of written Code of Ethics, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, coding and billing risk areas, and financial relationships with physicians and other healthcare professionals.

A. Policies and Procedures & Work Plan Activities

Policies and Procedures

Developed, updated, and performed triennial reviews on multiple system policies related to general compliance, governance, and HIPAA. Functioned as a reviewer for numerous organizational policies with compliance and/or privacy elements. Continue to participate on the CCH Policy Review Committee to ensure uniform system-wide standards are met.

Work Plan Activities

In addition to policy and procedure activity, Corporate Compliance worked with operational areas to assess compliance with procedures and/or regulatory requirements.

- Annual Education

  Responsibility for the ongoing operations and day-to-day management of the CCH electronic learning management system (LMS) for all mandatory annual training for the entire CCH workforce (employees and contractors) was transitioned to Wayne Wright, Director of Organizational Development and Training in Human Resources.

  Corporate Compliance remained subject matter expert for two (2) mandatory annual education modules, Fraud, Waste, and Abuse and Code of Ethics. Both modules were updated in to comply with regulatory and contractual requirements. In addition to maintaining responsibility for other elective modules relating to safeguarding protected health information.

- Record Retention

  As a government entity, all documents must be reviewed to determine if they are considered "public records." Public record is defined in 50 ILCS 205/3 is defined as *"(a)ny book, paper, map, photograph or other official documentary material, regardless of physical form or characteristics, made, produced, executed or received by any agency…or in connection with the transaction of public business and preserved…as evidence of the*

organization, function, policies, decisions, procedures, or other activities thereof, or because of the informational data contained therein.

CCH follows an approved Application for Authority to Dispose of Local Records, known as the Record Retention Schedule. The Schedule dates back to 1985, it contains 1,237 pages with 4,395 different records and retention periods. Over the past year, Corporate Compliance has requested and received permission to destroy each record on the Records Retention Schedule based upon the regulatorily defined retention period.

With the completion of the new Professional Building at 1950 West Polk, Corporate Compliance coordinated significant efforts to educate staff on record retention and appropriate record destruction. Corporate Compliance also worked with Health Information Management to walk through each floor of the Administrative Building and communicate proper identification and retention of documents prior to the Administrative Building being vacated by a majority of its workforce.

Departmental efforts with the aforementioned activity deferred a project to update the current Record Retention Schedule to a leaner, more intuitive document for Cook County Health. This project remains on the Corporate Compliance work plan for FY19.

- Dual Employment and Accounting of Disclosure Surveys

  To support organizational transparency, worked with Business Intelligence to internally develop a survey for all Cook County Health employees that combines two (2) elements, dual employment and conflict of interest.

  Completion of an annual Dual Employment survey is required whether or not a CCH employee participates in external employment. This requirement is promulgated by the Rules of the Board of the Cook County Commissioners, CCH Dual Employment Policy and CCH Personnel Rules.

  Historically, a subgroup of CCH employees, those that influence procurement or function in any decision-making capacity on behalf of CCH, were required to disclose additional information related to external relationships and activities. The purpose of this survey is to assess whether a conflict of interest exists. This survey is a mandatory requirement pursuant to the CCH Conflict of Interest policy. This year, the conflict of interest questions were incorporated with the dual employment questions resulting in one survey for all employees. This survey collects employee disclosures for review by leadership.

The survey requires a two-step review process. Once completed by an employee, the survey is submitted to their operational leader. The operational leader reviews the submission. Once reviewed and approved, the survey is routed for a secondary review by the operational leader's supervisor. At each step of the review, the reviewer has the ability to reject a submission, sending the survey back to the individual for more specificity. Summary information will be compiled and shared with the Corporate Compliance Executive Steering Committee.

- 340B Compliance
  Administered through the Health Resources and Services Administrations (HRSA) Office of Pharmacy Affairs, the 340B Drug Pricing Program has significant program integrity requirements. Corporate Compliance continued to function as a resource for the organization's 340B Drug Pricing Program managed within the Department of Pharmacy that requires drug manufacturers to provide outpatient drugs to eligible health care organizations such as CCH at significantly reduced prices.

Element 2

The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

B. Compliance Office and Committees

The graphic below illustrates the communication and reporting structure. Cathy Bodnar, the Chief Compliance & Privacy Officer, reports to the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors.

The primary duties of the **Chief Compliance & Privacy Officer** include the following:

- Serving as an internal consultant and resource for compliance and matters;
- Overseeing and monitoring the ongoing functions of the Corporate Compliance Programs for both the CCH provider side of the system and the CountyCare health plan;
- Participating in regular, CCH-wide risk assessments to understand potential vulnerabilities;
- Acting as the Privacy Officer for CCH to assure compliance with HIPAA regarding protection of patient and member health information;
- Reporting on a regular basis to the CCH governing bodies;
- Periodically revising the Corporate Compliance Program Plan, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of CCH and the laws and policies of federal, state, and county bodies;
- Developing, coordinating and participating in training programs that focus on the elements of the Corporate Compliance Program and providing training such that workforce members are knowledgeable of and comply with the Code of Ethics, compliance policies, laws and regulations;
- Coordinating and overseeing compliance auditing and monitoring activities;
- Responding to reports of issues or suspected violations related to compliance by independently investigating these matters, as appropriate, and working with operational leadership, Human Resources, and General Counsel in the determination of corrective action warranted based on policies;
- Assuring, through consultation with Human Resources and General Counsel, that guidance provided through CCH disciplinary policies are applied fairly, equitably, appropriately, and consistently;
- Developing policies and programs that encourage CCH personnel to report suspected fraud and other improprieties without fear of retaliation or retribution; and
- Reviewing and incorporating updated compliance, privacy, and security language within agreements and contracts to require third party vendors' adherence to applicable regulations and laws.

The **Audit & Compliance Committee of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management.

In addition to the aforementioned relationships, the Chief Compliance and Privacy Officer receives support and guidance from the internal **Corporate Compliance Executive Steering Committee**, an assembly of executive leaders within CCH, including but not limited to, the CEO, Deputy CEO, System Director of Internal Audit, Chief Medical Officer, and others.

Element 3

The development and implementation of regular, effective education and training programs for all affected employees.

C. Education and Training

1. *New Employee Orientation*
   Presented an "Introduction to Corporate Compliance and HIPAA", at twenty-seven (27) orientation session speaking to over 1,200 workforce members.

2. *Targeted Education*
   Provided thirty-seven (37) additional education training sessions to 485 attendees. Continued utilizing interactive training sessions which focused on story-telling as a means to communicate information on HIPAA and CCH policies. Focused on current matters brought to Corproate Compliance attention, the impact on patients, and proactively improving compliance to areas such as,
   - Resident program coordinators;
   - Residents in surgical units;
   - Patient Access Department;
   - Outpatient clinics;
   - CORE Center;
   - Physical Therapy/Occupational Therapy;
   - Oak Forest Mail Order Pharmacy; and
   - Correctional Health at Juvenile Temporary Detention Center.

3. *Annual Compliance Education*
   As noted earlier in this report, updated two (2) annual education modules on the Code of Ethics and Fraud Waste and Abuse.

Element 4

The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

D. Effective Lines of Communication – Receiving and Responding to Complaints

1. *Infrastructure Activities*
   a. Assisted our workforce members through:
      - A hot line service by a third party to preserve anonymity if desired. The individual is given a code number related to their report, and can call back or check the website using that code number to review comments and updates.
      - A separate toll-free number for privacy breaches.

- Expanded role in collaborating with Patient Relations to assist in resolving compliance-related issues.

b. Managed two (2) e-mail addresses for Compliance (compliance@cookcountyhhs.org) and Privacy (privacy@cookcountyhhs.org).
c. Established and engaged internal and external resources to assist with investigations and provide governmental and national perspectives on compliance issues.
d. Identified trends and patterns to mitigate organizational risks and facilitate operational improvement.
e. Presented trends and patterns to the Audit and Compliance Committee of the Board.

2. *Process for Responding to Inquiries, Issues and Complaints*

The work flow process follows:

a. Investigate the allegation;
b. Determine the area(s) affected;
c. Collaborate with operational leadership and appropriate departments;
d. Review and follow organizational policy, federal, state, and county regulations related to the incident for mitigation and remediation. These may include further auditing of documentation, mitigating harm and potentially informing the appropriate government entity;
e. Follow HIPAA breach notification rules that require sending a notification and apology letter to the affected individual(s), reporting to the Centers for Medicare and Medicaid (CMS), and, in the case of breaches that affect over 500 individuals, notifying the media;
f. Collaborate with operational area to determine and facilitate a corrective action plan including education as needed;
g. Respond to the complainant; and
h. Respond to governmental entities as required by law. (e.g. CMS, OCR, HFS).

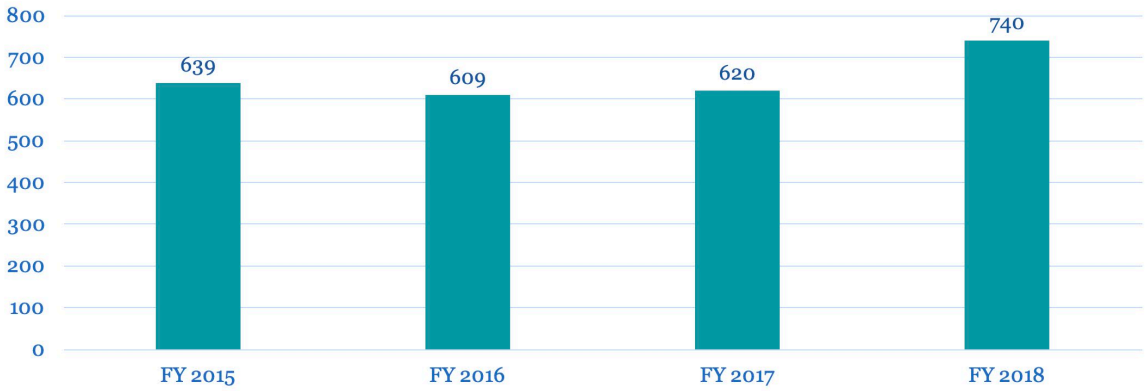
All contacts brought to the attention of Corporate Compliance are tracked through a web-based tracking tool. The Compliance Program utilized one vendor for 8-years to maintain consistency in tracking and monitoring. With the advancement of technology, it was prudent to assess the current marketplace. A Request for Proposal was posted, and six (6) vendors responded. A committee evaluated the respondents and chose a vendor based upon their commitment to provide hands-on management of the project and full implementation of the Compliance Issue Tracking Tool and leveraging a partnership with Salesforce, an existing CCH vendor currently utilized within Human Resources, to provide the software platform.

The overarching goal of the process is to assure consistency and to implement protections for our patients/members, the organization, our workforce, the government and the taxpaying public at large. The diagram that follows illustrates the approach to incident investigation and ensures that all the causes are uncovered and addressed by appropriate actions.

3. *Contact Volumes*

In FY18, 740 identified contacts were documented for the CCH Provider Compliance Program. The chart that follows illustrates the year-over-year activity which shows an increase of 120% compared to the previous fiscal year.

Year-Over-Year Volumes



4. *Contact Breakdown by Category*

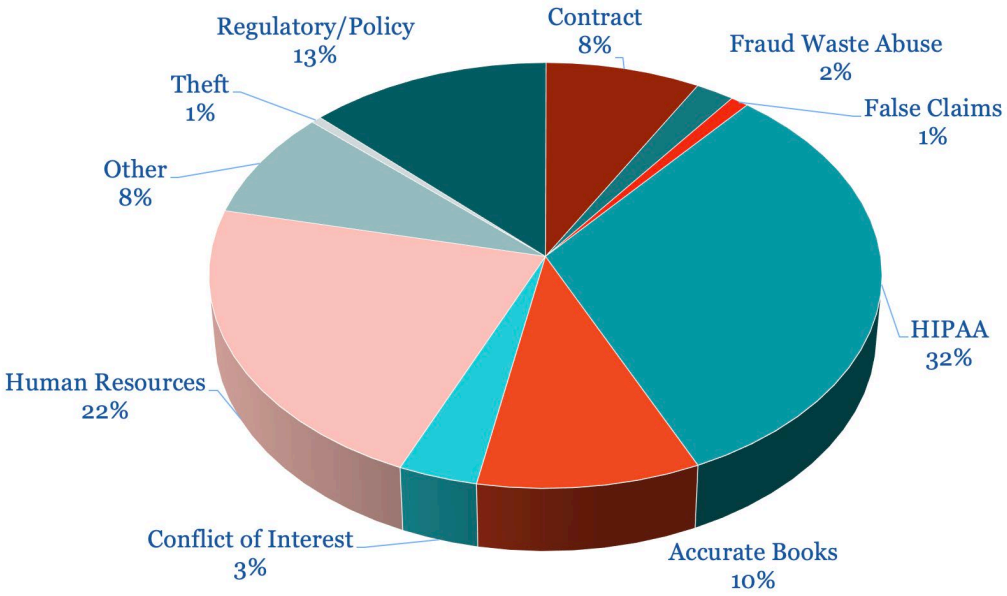
Categories have been defined that parallel the CCH Code of Ethics. The inclusion of a contact in a specific category does not substantiate the contact as a concern; rather it classifies the contact within a defined category.

The categories are classified as follows:

- Accurate Books and Records
- Conflict of Interest
- Contracts*
- False Claims
- Healthcare Fraud, Waste and Abuse
- HIPAA Privacy, Confidentiality and Security
- Human Resources
- Research
- Regulatory/Policy
- Theft
- Other

* Based upon the volume of activity surrounding contract review, separated this category from the previous category of Regulatory/Policy/Contract

5. *FY18 Contacts by Category*



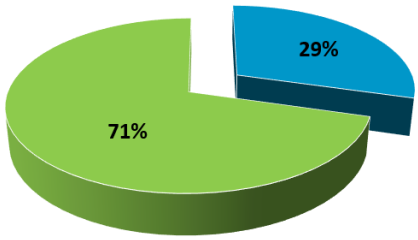
Categories			
HIPAA (Privacy/Security)	237	Conflict of Interest	26
Human Resources	163	Fraud Waste & Abuse	15
Regulatory/Policy	94	False Claims	7
Accurate Books	73	Theft	4
Contracts	60	Other	61

The majority of the contacts, 237 or 32%, were categorized within HIPAA Privacy. This percentage is consistent with previous years. Of the documented contacts categorized as HIPAA Privacy, approximately 15% or 37 contacts were confirmed privacy breaches that resulted in a total of 82 patient notifications.

The CCH Provider side of the Compliance Program provides support to the health plan for privacy issues. CountyCare experienced one (1) privacy breach that resulted in a total of five (5) member notifications. The one CountyCare breach in FY18 was caused by a Business Associate.

6. *FY18 Contact Status*
Of the 740 contacts were addressed throughout FY18, 96% or 709 contacts were resolved. Of the contacts resolved, More than 99% were either managed internally by Corporate Compliance or Corporate Compliance partnered with another area to address the concerns raised. Less than 1% were referred to other areas external to Corporate Compliance for management and follow-up. This metric is consistent year-over-year. The remaining 31 contacts were remained open at the end of the fiscal year and were carried over to FY19.

7. *FY18 Proactive vs. Reactive*
Of the 740 provider contacts managed during FY18, 29% or 218 contacts were proactive. The proactive category is defined as subjects, brought to the attention of Corporate Compliance by individuals seeking guidance prior to the occurrence of an event or activity. This percentage has decreased from 40% in FY17. The remaining 522 contacts or 71% were reactive. Reactive contacts are defined as contacts that occurred that were reported to Corporate Compliance after the occurrence.



Element 5

The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

E. Enforcing Standards

Broadened the scope of Standards enforcement through:

1. **Breach Assessments.** Reviewed investigations and provided remediation guidance to operational areas to minimize and/or eliminate breaches in the future and, utilized

the CCH Sanction Policy and Personnel Rules, to provide leadership guidance for disciplinary action.

2. **Breach Notification.** Investigated all instances of lost or stolen patient information, including paper and electronic. For all instances in which the data loss constitutes a breach as defined by the Breach Notification Rule, the breach notification requirements to the patient, the Secretary of HHS, and the media are completed. Corrective action plans are created and executed to improve the processes and counsel the physicians and employees involved.

3. **Conflict of Interest.** Provided guidance and developed Conflict Management Plans to preserve the integrity of the decision-making process.

4. **Investigations Resulting in Employee Related Corrective Actions.** HIPAA and Conflict of Interest complaints were investigated and resulted in providing leadership guidance to remediate the situations and avoid repetition of the incident.

5. **Partnerships with Governmental Agencies.** Corporate Compliance has engaged both state and federal agencies (e.g. the Department of Healthcare and Family Services (HFS) Office of the Inspector General, Medicaid Fraud Control Unit, Office for Civil Rights, Federal Bureau of Investigations, and the Secret Service) on a variety of matters. Additionally Compliance has worked with the Cook County Office of the Independent Inspector General.

Element 6

The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area.

F. Auditing and Monitoring

1. The Corporate Compliance Program conducted ongoing HIPAA auditing and monitoring during the relocations out of the Administrative building as follows:
    - Providing proactive record retention guidance throughout the move;
    - Monitoring garbage bins and vacated offices for PHI and working with operational leadership to educate staff when PHI was found;
    - Engaging Health Information Management when original medical record information was identified;
    - Communicating to the appropriate operational area(s) when other non-HIPAA contacts were identified related to the move (e.g. sharps and equipment found.)
2. The Corporate Compliance Program also served a resource to Internal Audit for outpatient coding expertise.

G. Risk Assessment

The Corporate Compliance Program risk assessment process is dynamic and adjustments are made throughout the year to respond to emerging issues with the resources available. This report highlighted activities that minimized risk through the introduction and enforcement of policies and standards, auditing and monitoring, education, and issue investigations with corrective action plans as appropriate.

Through surveys of executive leadership and key thought leaders within the organization, industry risks, and through the course of activities within prior fiscal years, the following areas were assessed in FY18:

- Securing Protected Health Information in paper and electronic and paper format through encryption and secure storage devices;
- Monitoring patient data to ensure accurate registration and deter identity theft and merged electronic health records;
- Directing Supply Chain Management during contract negotiations in the areas of compliance, privacy and security;
- Ensuring documentation supports the services performed through accurate code assignment;
- Defining contractual parameters of governmental Managed Care Plans excluding CountyCare;
- Assuring sanction screening was performed during the onboarding process for employees and vendors;
- Monitoring the 340B Drug Pricing Program through Pharmacy;
- Collaborating with Research to ensure regulatory requirements are followed;
- Guiding leadership in Record Retention and Storage requirements; and
- Working with physicians through the Illinois Drug Prescription Monitoring Program to eliminate fraudulent controlled substance prescriptions.

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

Sanction Screening Checks

- Continued to address regulatory requirements to avoid employing, engaging, contracting or agreeing with any individual or entity that is excluded or "sanctioned" from participation in a federal health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services.
- Determined, through an independent third party, no excluded or sanctioned CCH workforce members or vendors were identified throughout this fiscal year.

V. Looking Ahead

Overarching priorities have been established for CCH Corporate Compliance, to:

- Serve as a resource for our patients, our staff, and the public at large;
- Investigate all contacts/complaints brought to the attention of the Program;
- Promote the CCH Corporate Compliance Program internally and externally.

In addition, as noted earlier, through an annual risk assessment with executive leadership and key thought leaders, identification of emerging issues, and through the course of activities within prior fiscal years priorities have been identified. The Corporate Compliance Program will primarily focus on analysis and risk reduction related to fraud, waste, and abuse initiatives and continue to review, update and implement compliance policies and procedures.

FY19 priorities on the CCH provider side will focus on the following:

- Communication of importance of safeguarding hard copy Protected Health Information (PHI) to workforce members and their departments and provide guidance on record retention parameters and secure destruction processes as warranted;
- Development and compilation of a leaner, intuitive Records Retention Schedule for submission to the Local Records Commission. Once approved, append the current Records Retention policy and communication the update to the CCH workforce;
- Continuation of our partnership with IT Security to examine processes to safeguard electronic protected health information or ePHI as technological challenges arise (e.g. social media, texting, image sharing, etc.);
- Collaboration with Revenue Cycle operations to deter identity theft and merged electronic health records;
- Participation in continued oversight of the 340B Drug Pricing Program;
- Communication to accentuate the need for providers to manage their prescription activity with the Illinois Drug Prescription Monitoring Program to eliminate fraudulent controlled substance prescriptions;
- Oversight of auditing and monitoring code assignment based on medical record documentation and documentation guidelines; and
- Assessment of compliance with third party Managed Care contracts.

CountyCare Compliance Program

Annual Report
Fiscal Year 2018
December 1, 2017 – November 30, 2018

February 28, 2019

Table of Contents

I. Introduction

CountyCare is a Managed Care Community Network (MCCN) health plan offered by Cook County Health (CCH) pursuant to a contract with the Illinois Department of Healthcare and Family Services (HFS). Since late 2012, CCH has partnered with the State of Illinois, initially through the State of Illinois federal Section 1115 demonstration waiver which was an early start on Medicaid expansion, then in 2014, CountyCare transitioned into the MCCN. By working to employ the advantages of our parent organization, CCH, CountyCare is able to uniquely promote achievement of the Triple Aim: 1) improving the member experience, 2) improving the health of populations overall, while 3) reducing the cost of care. The operation of the CountyCare MCCN is facilitated through CCH and its various subcontractors.

To adhere to the Centers for Medicare & Medicaid Services (CMS) Managed Care Program Integrity requirements[1], contractual provisions in the MCCN Agreement with HFS, and the elements of an effective compliance program as recommended in the Department of Health and Human Services Office of Inspector General (OIG) Compliance Program Guidance publications, CountyCare developed and implemented the CountyCare Compliance Program. The CountyCare Compliance Program is designed to demonstrate the health plan's ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and Code of Ethics/Standards of Conduct.

This Annual Report presents the activities throughout county fiscal year 2018. The CountyCare Managed Care Compliance Program is under the executive leadership of Cathy Bodnar, Chief Compliance and Privacy Officer, and the operational leadership of Elizabeth Festa, CCH Compliance Officer dedicated to CountyCare.

During this past fiscal year, CountyCare Health Plan, as a whole, accomplished many goals and implemented a variety of initiatives. A few health plan achievements include:

- CountyCare Became the Largest Medicaid Health Plan in Cook County: In FY2018, CountyCare acquired the Medicaid membership of both Aetna and Family Health Network (FHN), becoming the largest Medicaid Health Plan in Cook County.
- Medicaid Redetermination Efforts: CountyCare sought to retain membership by helping members with their Medicaid redetermination process. Triggers were developed for providers, prompts were embedded within providers' health information systems, and redetermination events throughout the county were held to help members maintain their Medicaid eligibility and CountyCare membership.
- CMS Review of Illinois Medicaid Program Integrity Activity: CMS conducted a focused review of Illinois Medicaid to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by a random selection of the state's managed care organizations. CountyCare

[1] See 42 C.F.R. §438.608.

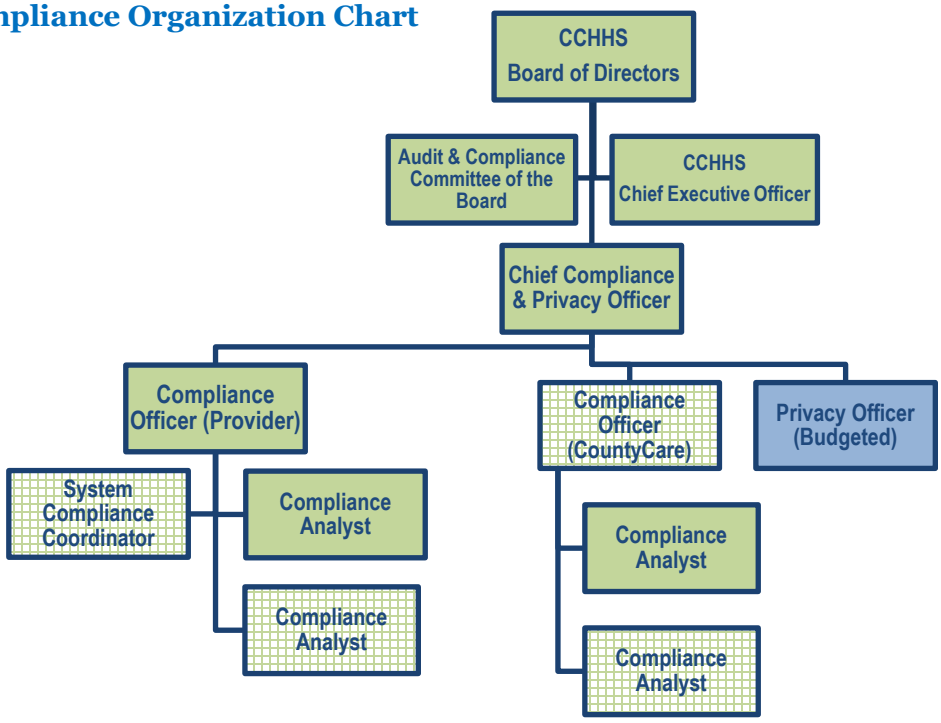
was selected, supplied numerous documents to support program integrity efforts, and Corporate Compliance travelled to Springfield to participate in interviews with CMS and HFS, strengthening its relationship with both entities and providing valuable insight into the Program Integrity activities of CountyCare.

The Corporate Compliance Program dedicated to CountyCare was directly involved in each major initiative to assure the execution adhered to and incorporated relevant regulatory directives and contractual requirements.

II. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the structure and activities of the Program that incorporate efforts to foster an infrastructure that produces a comprehensive compliance program for CountyCare and its affiliates. The existing Departmental Organization Chart follows:

Compliance Organization Chart



The lightly shaded positions indicate the new hires within FY18. Two (2) of the 3-dedicated CountyCare Compliance Program positions were vacant for several months within the fiscal year, including the Compliance Officer assigned to CountyCare. This placed a significant strain on the existing resources. In the interim, Cathy Bodnar, functioned in an operational leadership capacity with significant, noteworthy support from Cory Otto, Compliance Analyst. Management of the core elements of the Program continued which was critical to the ongoing success of the CountyCare Compliance Program.

CountyCare Compliance Program Scope

The CountyCare Compliance Program is tasked with outlining guidelines and providing insight to:

- Comply with the CMS Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan contract with HFS;
- Prevent, detect and eliminate fraud, waste, abuse, and financial misconduct;
- Protect health plan members, providers, CCH, the State, and the taxpaying public from potential fraudulent activities;
- Respond and provide guidance related to privacy, confidentiality, and security matters;
- Provide high level oversight to the health plan's Grievances and Appeals Program; and
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

Further, the program aims to implement a working communication strategy to increase the CountyCare workforce awareness, including vendors and subcontractors, of the following topics:

- Code of Ethics;
- Privacy, Confidentiality, and Security;
- Accessibility of the Compliance Officer and the compliance team;
- Availability through multiple modalities;
- Responsibility to report potential/actual issues;
- Consequences of not reporting; and
- Non-retaliation.

The following types of activities fall into the CountyCare Compliance Program purview:

- Interpretation of contracts, laws, rules, regulations, and organizational policy as they relate to CountyCare Compliance
- Accurate Books and Records
- Anti-kickback Activities
- Conflict of Interest
- False Claims
- Financial Integrity
- Fraud, Waste and Abuse
- Member Privacy, Confidentiality, and Security (HIPAA)

The CountyCare Compliance Program scope of work is subject to ongoing review and revision as deemed necessary to ensure ongoing compliance. It is designed to accommodate future changes in regulations and laws and may be updated to address activities not currently covered, issues related to new service offerings, or regulatory requirements.

III. Compliance Program Structure – Performance of the Elements

This section of the report serves to demonstrate the effectiveness and provide an assessment of program operations using the seven (7) Compliance Program Elements of a comprehensive compliance program, as outlined in the CMS Managed Care Program Integrity requirements[2] and by contractual provisions in the MCCN Agreement.

Element 1

The distribution of written Code of Ethics, as well as written policies and procedures that promote the health plan's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, waste and abuse. The CCH Code of Ethics applies to all CountyCare personnel, providers, agents and subcontractors. The Code of Ethics, as well as CCH's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

A. Policies and Procedures.

Compliance staff engaged in the following activities to promote and establish an effective compliance program for the CountyCare Health Plan:

1. Incorporated new and revised 2018 MCCN contractual language into vendor contracts and Requests for Proposals.
2. Continued to follow the CountyCare Compliance Plan that focuses exclusively on outlining the compliance responsibilities of the health plan and program design for implementation, as well as specific CountyCare compliance policies for high risk areas focused on health plan operations.
3. Ensured that CountyCare personnel, providers, agents and subcontractors had access to compliance documentation electronically and were provided with hard copies of compliance policies and procedures upon request.
4. Obtained copies of compliance related policies and procedures, where needed, from Evolent, CountyCare's Third-Party Administrator (TPA) and the various delegated vendors providing services for CountyCare.
5. Reviewed, in conjunction with the TPA, twenty-four (24) policies addressing the following areas,
    - Fraud, Waste, Abuse, and Financial Misconduct;
    - Compliance Auditing and Monitoring;
    - Provider Audit and Recovery and Appeals Process;
    - Compliance Reporting and Non-Retaliation;
    - Exclusion Screening, License Verification, and Background Checks;
    - Conflict of Interest;
    - Delegated Entity Oversight/Monitoring;

[2] See 42 C.F.R. §438.608.

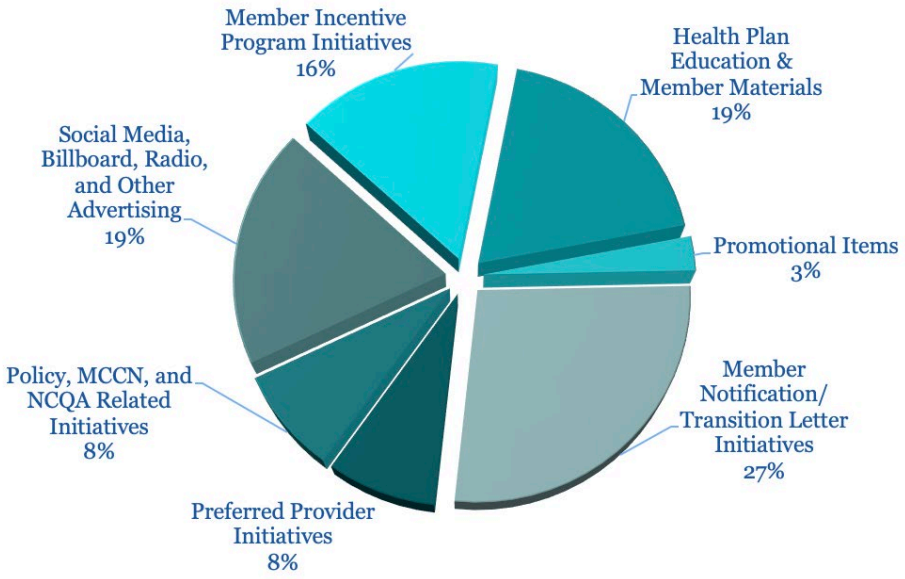
- Health Plan Marketing; and
- Subpoena Handling.

B. Ad Hoc Activities/Guidance

Corporate Compliance worked with operational areas to assess compliance with policies, procedures and/or regulatory requirements and, in certain instances, assisted in the development of new policies and procedures.

Examples of areas assessed:

- Health Plan Marketing Policy Compliance Review: Due to the ever-changing complex regulatory environment of Medicaid managed care plan marketing, Compliance reviewed and tracked all marketing materials before they were submitted to HFS for approval. In FY18, Compliance conducted 37 marketing and material reviews. 36 of 37 reviews conducted were approved by Compliance and subsequently, HFS. Each CountyCare initiative reviewed may contain multiple materials, however, each review is counted individually.



- Medical and Prior Authorization Policies: Worked with Evolent, CountyCare's TPA, to compile all medical payment and prior authorization policies and to identify areas of need.
- Authorized Representatives: Provided written guidance to the member call center regarding when they could speak with a member's representative based on a verbal consent.

- Abuse, Neglect, and Exploitation: Analyzed and provided guidance to CountyCare operations on the role as a mandated reporter of Critical Incidents and potential Abuse, Neglect, and Exploitation of members.
- New Prior Authorization and Utilization Management System: Partnered with the CountyCare Quality Department to ensure the upgraded method for communicating prior authorizations and delivering care management comports with accepted privacy and security standards.

Element 2

The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.

C. Compliance Office and Committees

Cathy Bodnar, the Chief Compliance and Privacy Officer, reports to both the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors.

The CCH Compliance Officer responsible to assist the Chief Compliance and Privacy Officer in the operation of the CountyCare Compliance Program is Elizabeth Festa. The primary duties of the Compliance Officer assigned to CountyCare include the following:

- Serving in a leadership capacity to develop the CountyCare Compliance Program in conjunction with the Chief Compliance and Privacy Officer;
- Collaborating with CountyCare operational leadership to facilitate operational ownership of compliance;
- Overseeing the Plan's Program Integrity Program;
- Participating in CountyCare risk assessments to understand potential vulnerabilities;
- Establishing a structured process for regulatory review, monitoring, and dissemination of information related to Corporate Compliance;
- Periodically revising the Corporate Compliance Program Plan, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management in light of changes directed to the needs of the health plan and the laws and policies of federal, state, and county bodies;
- Modifying policies, procedures, and projects to reflect changes in laws and regulations;
- Developing and coordinating compliance projects with CountyCare and delegated vendors;
- Performing interviews with all key personnel to validate compliance with established policies and procedures and applicable regulations in conjunction with other personnel, as deemed necessary;

- Completing ongoing assessments to evaluate potential strengths and weaknesses and to determine the adequacy of the overall CountyCare Corporate Compliance Program to ensure compliance, as deemed necessary;
- Providing guidance related to HIPAA and information sharing;
- Monitoring the health plan's Grievances and Appeals Program for patterns and trends while providing high level oversight;
- Providing recommendations to correct any potential weaknesses or areas of non-compliance discovered; and
- Performing follow-up reviews to ensure action plans have been adequately implemented.

The **Audit & Compliance Committee of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management. The Audit & Compliance Committee of the Board receives periodic updates regarding the CountyCare Compliance program, including Fraud, Waste and Abuse (FWA) metrics and assessments of risk areas.

The **CountyCare Compliance Committee**, chaired by the Compliance Officer assigned to CountyCare, meets monthly and provides oversight of and guidance to CountyCare operations to ensure regulatory compliance and fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Compliance Committee also reviews CountyCare activity pursuant to Compliance Program requirements and contractual requirements, including, but not limited to audits, monitoring activity, and corrective action plans. The Committee reports through the Chief Compliance and Privacy Officer to the Audit & Compliance Committee of the Board.

The **Fraud, Waste and Abuse Workgroup**, chaired by the CountyCare Compliance Officer with attendance by the Chief Compliance and Privacy Officer, transitioned from a monthly workgroup meeting to hoc committee convened to review the structure and effectiveness of the fraud, waste and abuse detection efforts.

The **CountyCare Executive Committee** is comprised of CCH senior delegates and CountyCare leadership and is responsible for providing oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider-sponsored organization. The Committee provides useful feedback to CountyCare leadership regarding Plan performance and promotes alignment between CCH objectives and CountyCare programs. The Committee meets once every two months.

The **HFS-OIG MCO Subcommittee** is comprised of HFS-OIG and Managed Care Organization's (MCO) compliance members involved in the program integrity functions of their respective MCOs. This subcommittee meets monthly to review and share

information regarding fraud, waste, and abuse activity as it relates to specific providers and trends.

Corporate Compliance **Program Integrity Meetings** with delegated vendors occur on a weekly, bi-weekly, and monthly cadence, depending on the vendor and amount of activity. Corporate Compliance oversees the vendors' activities and uses these meetings to approve, modify, or reject the direction of investigations and recoupment activity.

The **Delegated Vendor Oversight Committee** meets quarterly to provide oversight of the operations affecting the scope of functions of delegated vendors and subcontractors to ensure compliance with statutory and contractual requirements. The Committee also provides oversight of quarterly delegation audits, monthly joint operations meetings and regular monitoring of member and provider complaints. Identified areas of risk that fall under the purview of Corporate Compliance are referred to Corporate Compliance for assessment.

Element 3

The development and implementation of regular, effective education and training programs for all affected employees.

D. Education and Training

1. CountyCare – Provider MCCN Onboarding and New Employee/Contractor Orientation
    - Reviewed and updated provider onboarding orientation materials to fully incorporate corporate compliance requirements.

2. Targeted Education
    - Reviewed the MCCN Agreement for CountyCare training requirements and responsibilities and compared training materials submitted by the TPA and other delegated vendors to ensure compliance.
    - Provided regulatory summary regarding updates to 42 CFR Part 2 related to the disclosure of substance/alcohol abuse records.
    - Conducted a "HIPAA for Care Coordinators" and "HIPAA for Customer Service Members" targeted training for staff who work directly with members. Educated providers and care coordinators through guidance documents regarding HIPAA and information sharing for care coordination purposes. Created additional documents about HIPAA for care coordination staff who were part of the acquisition of FHN and Aetna membership.
    - Provided guidance to CountyCare employees regarding Power of Attorney documents and authority.

3. Annual CCH Compliance Education
    - Reviewed mandatory CCH training requirement to ensure that CCH trainings paralleled contractual and regulatory requirements for the health plan workforce. Identified need to include Critical Incident training for

CountyCare staff; reviewed classroom training content to validate contractual requirement was met.

Element 4

The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.

E. Effective Lines of Communication – Receiving and Responding to Complaints

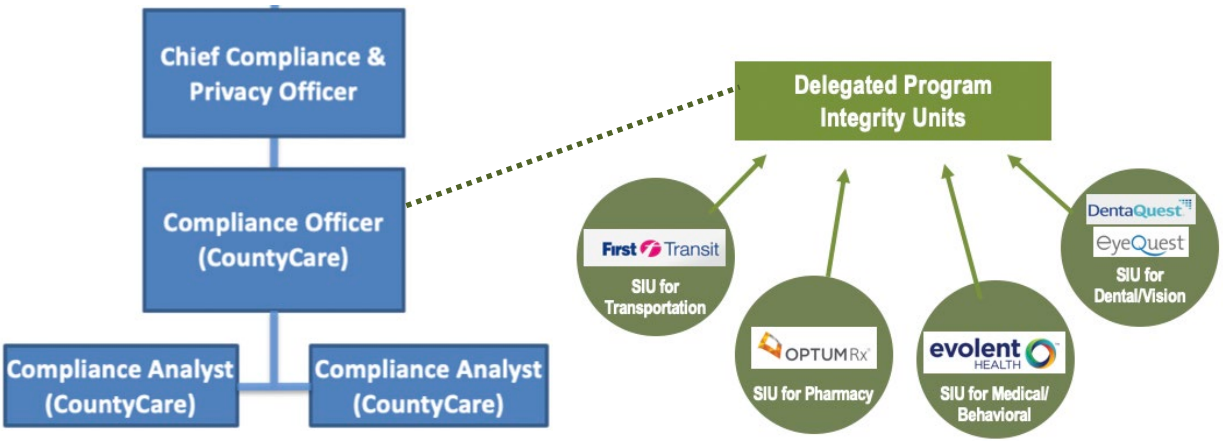
1. Infrastructure Activities
   - Monitored TPA's support and assistance to CountyCare members through the TPA's hotline service. Met weekly with TPA's compliance staff to discuss contacts received through the hot line and appropriate follow-up/responses.
   - Shared the accessibility of reporting concerns to the CountyCare workforce through:
     - A hotline service by a third party to preserve anonymity if desired;
     - A separate toll-free number for privacy breaches.
     - Open door policies of both the Compliance Officer assigned to CountyCare and the Chief Compliance and Privacy Officer;
     - Two (2) e-mail addresses for Compliance (compliance@cookcountyhhs.org) and Privacy (privacy@cookcountyhhs.org).
   - Established relationships and engaged internal and external resources to assist with investigations.
   - Identified trends and patterns to mitigate organizational risks and facilitate operational improvement.
   - Presented trends and patterns to the CountyCare Compliance Committee, CountyCare Executive Committee, Audit & Compliance Committee of the Board and the Managed Care Committee of the Board.

2. Process for Responding to Contacts and Complaints
   Maintained processes for contact, complaint management, and resolution as follows:
   - Investigated allegation;
   - Determined the area(s) affected;
   - Collaborated with operational leadership and appropriate entities;
   - Reviewed and followed contractual obligations, organizational policy, federal, state, and county regulations related to the incident for mitigation and remediation;
   - Determined and facilitated a resolution which may include a corrective action plan including education as needed; and
   - Responded to the complainant, as appropriate.

3. Reporting
   Categories have been defined to allow CountyCare Compliance to accurately measure general compliance contacts. The inclusion of a contact in a specific category does not substantiate the contacts as a concern; rather it classifies the contact within a defined category. The contacts addressed within the past fiscal year of CountyCare as a MCCN fell into the following categories:
   - Contractual Issues & Reviews
   - Regulatory/Policy Matters
   - HIPAA Privacy, Confidentiality and Security
   - Accurate Books & Records
   - Fraud, Waste and Abuse
   - Conflict of Interest
   - Other (e.g., subpoenas, unique grievance & appeals guidance, involuntary discharge of CountyCare member, etc.)

4. Fraud, Waste and Abuse
   Prevention, detection and elimination of fraud, waste, abuse, and financial misconduct is a key driver for CountyCare Compliance. Benefit and Program Integrity is critical not only because it a contractual requirement and a significant focus by the State and Federal government but because it is *the right thing to do*. The impetus of this key initiative is to ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse in addition to protecting health plan members and providers.

   To identify potential fraud, waste, abuse, and financial misconduct, CountyCare Compliance partners with each delegated vendor through their dedicated areas commonly known as Special Investigation Units (SIU). The CountyCare Compliance Officer provides direct oversight of program integrity activity.



All Program Integrity activity is tracked by State Fiscal Year (S-FY) for state reporting purposes and not by county fiscal year. The S-FY runs from July 1st through June 30th.

FWA activity matters are raised through multiple modalities, to each delegated vendor or directly to Corporate Compliance. All allegations are tracked and monitored to resolution. In addition, other measures are undertaken through the SIUs. CountyCare utilizes data mining to identify providers with aberrant billing patterns and researches tips received from HFS, HFS-OIG, other Managed Care Organizations (MCOs), healthcare fraud groups, CountyCare employees, the media and other sources to identify overpayments.

Metrics for the S-FY18 follow:

Reporting Quarter	Tips	Preliminary Investigations	Full Investigations	Referrals to HFS-OIG	Audits	Overpayments Identified	Overpayments Collected
Q1 07/01 – 09/30/17	1	11	3	3	3	$ 97,910.84	$ 2,574.00
Q2 10/01 – 12/31/17	2	8	9	1	1	$ 201,038.64	$ 2,961.36
Q3 01/01 – 03/31/18 *	70	5	15	2	103	$ 457,245.29	$ 6,097.85
Q4 04/01 – 06/30/18	6	5	9	2	57	$ 2,305,959.74	$ 28,216.99

* The 3rd Quarter S-FY 18 was significant for CountyCare Compliance. Evolent, CountyCare's TPA for medical and behavioral health, hired two (2) local investigators dedicated solely to program integrity efforts. This dedicated team partnered with a data analytics firm to review claims for anomalies. The result of this activity is apparent in the metrics above.

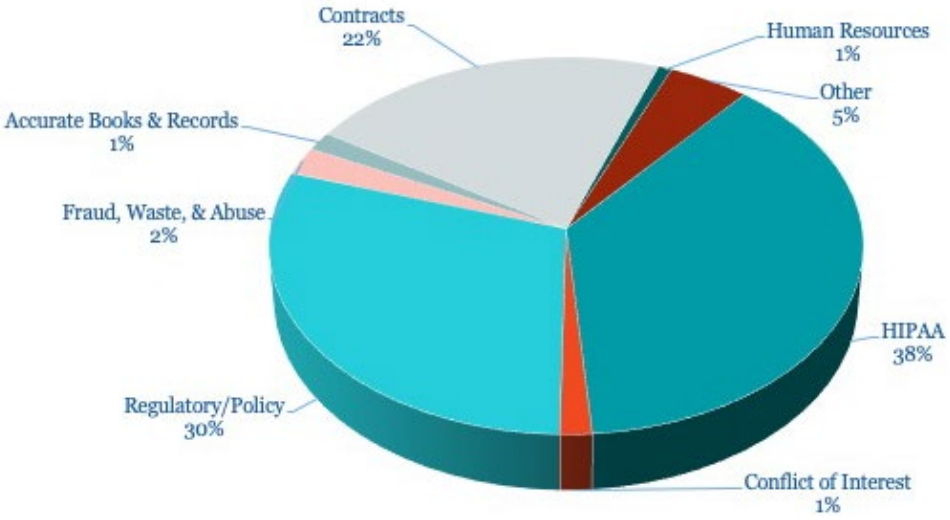
CountyCare Compliance monitored the process to ensure that appropriate action was taken, including reporting of suspected FWA to the State HFS-OIG.

In S-FY 2018, CountyCare referred 11 cases to the HFS-OIG for possible fraud, waste or financial misconduct.

5. Total Volume of General Compliance Contacts
In addition to the program integrity efforts above, a total of 125 general compliance contacts were tracked by CountyCare Compliance during the last fiscal year. This is a 29% decrease from last year. As noted earlier in this annual report, two (2) of the three (3) dedicated CountyCare Compliance Program positions were vacant.

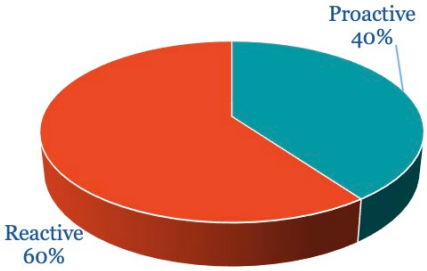
This placed a significant strain on the existing resources from March through August 2018. CountyCare Compliance had one full-time Compliance Analyst, Cory Otto. In the interim, Cathy Bodnar, functioned in an operational leadership capacity and with external resources providing supplemental assistance.

6. Contact Breakdown by Category (December 1, 2017-November 30, 2018)



Categories			
HIPAA (Privacy/Security)	47	Conflict of Interest	2
Regulatory/Policy	37	Accurate Books & Records	2
Contracts	27	Human Resources	1
Fraud Waste & Abuse	3	Other	6

With limited resources, CountyCare Compliance focused on contacts and issues that presented, shifting the balance from proactive to reactive or unanticipated queries or concerns. Of the 125 CountyCare contacts in FY 18, 40% or 50 contacts, were proactive. This was a significant decrease from the previous fiscal year, where 81% of the contacts were proactive activities that anticipated possible issues. The gradual return to a proactive paradigm is anticipated with the resolution of staffing issues.



7. HIPAA (Privacy and Security)
   As a covered entity, the health plan is required to safeguard privacy for plan members. Privacy and security of member information is highly regulated, and this category accounted for 47, or 38% of all contacts handled by compliance.

   During FY2018, CountyCare had fifteen (15) HIPAA incidents. None of the incidents required notifications to members. Twelve (12) of the fifteen (15) incidents were misdirected communications sent to another covered entity (another health plan, for example) or business associate (an entity doing business on behalf of the health plan).

8. Grievances and Appeals Activities
   The responsibility for Grievance and Appeals activity transitioned from Corporate Compliance to CountyCare Operations this fiscal year, specifically to leadership within Quality and Risk Management. CountyCare Compliance provides high-level oversight and remains committed to ensuring that contractual and regulatory timeframes are met, to providing guidance and assistance when necessary, and participating in the quarterly CountyCare Grievance and Appeals Committee.

Element 5

The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or Federal health care program requirements.

F. Enforcing Standards

Broadened the scope of Standards enforcement through:

1. **Fraud, Waste and Abuse Monitoring.** As noted earlier in this report, CountyCare Compliance collaborated closely with the Special Investigation Units of Delegated Vendors to identify potential fraud, waste, abuse, and financial misconduct. Towards the end of the county fiscal year, Evolent, CountyCare's TPA for medical and behavioral health shifted to a second data analytics firm recognized for its expertise in DRG auditing and coding analysis.

2. **Privacy and Security (HIPAA) Breach Assessments.** As staffing for CountyCare Compliance stabilized, the area began to assume a greater responsibility for performing breach assessments. To maintain consistency in the approach, CountyCare Compliance partnered with CCH Provider Compliance to review allegations. If a privacy or security breach is validated, CountyCare Compliance provided remediation guidance to operational areas to minimize and/or eliminate breaches in the future and, utilized the CCH Sanction Policy and Personnel Rules, to provide leadership guidance for disciplinary action.

3. **Investigations Resulting in Employee Related Corrective Actions.** Investigated Conflict of Interest and confidentiality complaints and provided employee guidance.

4. **Partnerships with Governmental Agencies.** CountyCare Compliance partnered with the HFS, HFS-OIG, and Illinois' Medicaid Fraud Control Unit (MFCU).

5. **Partnerships with non-Governmental Agencies**. CountyCare Compliance was invited to participate with a number of new organizations related to the detection of fraud and wrongdoing in the insurance industry. These non-governmental organizations include the HealthCare Fraud Prevention Partnership (HFPP), National Insurance Crime Bureau (NICB), and Midwest Anti-Fraud Insurance Association (MAIA).

Element 6

The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas.

G. Auditing and Monitoring

- Fraud, Waste, Abuse and Financial Misconduct
  As noted earlier in this report, CountyCare Compliance continued its partnership with SIUs, meeting regularly to build a robust system to identify potential financial misconduct, and formed partnerships with governmental and non-governmental agencies.
- Annual Compliance Attestation
  CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare's delegated vendors in April 2018. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, including distribution of a Code of Ethics, FWA policy distribution, training and education requirements, sanction screening checks, and delegated oversight. All of the vendors responded, and one vendor required corrective measures.

H. Risk Assessment

The focus within CountyCare Compliance is prevention, detection and elimination of fraud, waste, abuse, and financial misconduct, however other areas of risk relating to member privacy and security of protected health information were identified in FY18. These also require ongoing assessment:

- Necessity for updated procedures to terminate employee access to 3rd party electronic systems upon separation from employment and to monitor current employee access.
- Disclosure and sharing of member sensitive health information.

In addition, CountyCare Compliance will initiate an annual risk assessment with executive leadership and key thought leaders nationally to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

I. Identification of Systemic Issues

- Sanction Screening Checks
  Addressed regulatory requirements to avoid employing, engaging, contracting or agreeing with any individual or entity that is excluded or "sanctioned" from participation in a federal or state health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services through ongoing monthly checks with an external vendor.

IV. Looking Ahead

In FY19 the Corporate Compliance Program will continue to focus on maintaining adherence to contractual requirements and healthcare compliance best practices as the program matures. As CountyCare relies heavily on delegated vendors, monitoring for adherence to CountyCare policies, contractual, and regulatory standards are critical to avoid sanctions. The Program will continue ongoing activities related to risk reduction in the areas of compliance, policy implementation, and the development and implementation of monitoring and auditing efforts.

These priorities have been established for the CountyCare Compliance Program:

- Strengthen health plan oversight in the area of fraud, waste and abuse,
  - Foster continued partnerships with HFS-OIG and the State's MFCU to develop best practices in Corporate Compliance for CountyCare.
  - Enhance relationships with non-government organizations and other MCOs' SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.
- Continue to investigate all matters brought to the attention of the Program.
- Uphold compliance with contractual requirements and industry best practices as CountyCare continues as the largest Medicaid Managed Care Organization in Cook County.
- Foster partnerships with CountyCare Operations and delegated vendors to fulfill contractual obligations in Program Integrity and state reporting.
- Increase oversight and monitoring for all delegated vendors.
- Serve as a resource to the workforce and delegated vendors.
- Mature the CountyCare Compliance Program and continue to incorporate best practices to cultivate a culture of compliance throughout the health plan.
- Maintain CountyCare Compliance Program recognition locally and nationally.

ATTACHMENT #2

Audit and Compliance Committee

Internal Audit – Proposed Internal Audit Charter

March 15, 2019

COOK COUNTY HEALTH

Internal Audit

Open Meeting

Internal Audit Charter

COOK COUNTY HEALTH

Internal Audit Charter

(The following 3 slides are excerpts from the Institute of Internal Auditors (IIA) Practice Standards)

INTERNATIONAL STANDARDS FOR THE PROFESSIONAL PRACTICE OF INTERNAL AUDITING (STANDARDS)

Attribute Standards

1000 – Purpose, Authority, and Responsibility
The purpose, authority, and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Definition of Internal Auditing, the Code of Ethics, and the Standards. **The chief audit executive (CAE) must periodically review the internal audit charter and present it to senior management and the board for approval.**

Interpretation:
The internal audit charter is a formal document that defines the internal audit activity's purpose, authority, and responsibility. The internal audit charter establishes the internal audit activity's position within the organization, including the nature of the chief audit executive's functional reporting relationship with the board; authorizes access to records, personnel, and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities**. Final approval of the internal audit charter resides with the board.**

Internal Audit Charter

1110 – Organizational Independence

The chief audit executive must report to a level within the organization that allows the internal audit activity to fulfill its responsibilities. **The chief audit executive must confirm to the board, at least annually, the organizational independence of the internal audit activity.**

Interpretation:

Organizational independence is effectively achieved when the chief audit executive reports functionally to the board. Examples of functional reporting to the board involve the board:

- **Approving the internal audit charter;**
- **Approving the risk based internal audit plan;**
- **Approving the internal audit budget and resource plan;**
- **Receiving communications from the chief audit executive on the internal audit activity's performance relative to its plan and other matters;**
- Approving decisions regarding the appointment and removal of the chief audit executive;
- Approving the remuneration of the chief audit executive; and
- Making appropriate inquiries of management and the chief audit executive to determine whether there are inappropriate scope or resource limitations.

Internal Audit Charter

Considerations for Implementation

Based on this foundational work, the CAE (or a delegate) drafts an internal audit charter. The IIA offers a model internal audit activity charter that may be used as a guide. Although they vary by organization, charters typically include the following sections:

Introduction – to explain the overall role and professionalism of the internal audit activity, citing the relevant elements of the International Professional Practice Framework (IPPF).

Authority – to specify the internal audit activity's full access to the records, physical property and personnel required to perform its engagements and to declare its accountability for safeguarding assets and confidentiality.

Organization and Reporting Structure – to document the CAE's reporting structure. The CAE reports functionally to the board and administratively to a level within the organization that allows the internal audit activity to fulfill its responsibilities. This section may delve into specific functional responsibilities, such as approving the charter and audit plan, and hiring, compensating, and terminating the CAE; as well as administrative responsibilities, such as supporting information flow within the organization or approving human resource administration and budgets.

Independence and Objectivity – to describe the importance of internal audit independence and objectivity and how these will be maintained, such as prohibiting internal audit from having operational responsibility or authority over areas audited.

Responsibilities – to lay out major areas of ongoing responsibility, such as defining the scope of assessments, writing an audit plan and submitting it to the board for approval, performing assessments, communicating the results, providing a written audit report, and monitoring corrective actions taken by management.

Quality Assurance and Improvement – to describe the expectations for maintaining, evaluating, and communicating the results of a quality program that covers all aspects of the internal audit activity.

Signatures – to document the agreement between the CAE, a designated board representative, and the individual to whom the CAE reports, with the date, name, and title of signatories.

Thank you.

COOK COUNTY HEALTH

Cook County Health and Hospitals System (CCHHS)
Internal Audit Charter **March 22, 2018**

Mission
Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Internal Audit will align its activities with the mission and strategy of CCHHS. Internal Audit will promote good controls and serve as an educational resource to its stakeholders with respect to risk management, control and governance processes. Internal Audit will maintain a collaborative approach to its work practices and will ensure its work product provides value added outputs for its stakeholders.

Role
- Internal Audit's role is determined by the CCHHS Board of Directors through its Audit and Compliance Committee.
- Responsibilities are defined by the CCHHS Board of Directors through its Audit and Compliance Committee.

Professional Standards
- Internal Audit will govern themselves by adherence to the Institute of Internal Audit's "Code of Ethics". http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/
- The Institute's "International Professional Practice Framework" shall constitute the operating procedures for the department. These documents are considered an addendum to this Charter. http://www.theiia.org/guidance/standards-and-guidance/ippf/standards/
- Internal Audit will adhere to all CCHHS policies and procedures and all Internal Audit procedure manuals.

Authority
Internal Audit is authorized to:
- Have unrestricted access to all functions, records, property and personnel.
- Have free, open, and timely access to the Chief Executive Officer and the CCHHS Board of Directors through its Audit and Compliance Committee.
- Allocate department resources, set frequencies, select subjects, determine scope of work and apply the techniques required to achieve audit objectives.
- Obtain the necessary assistance of personnel in the organization when performing audits, as well as other specialized services from within or outside the organization.

Independence
- All audit activities shall remain free of influence by any element in the organization, including matters of audit scope, procedures, frequency, timing, or report content, required to permit the independence required to render objective reports.
- Internal auditors shall have no operational responsibility or authority over any activities they review.
- Internal auditors shall not develop or install systems or procedures, prepare records or engage in any other activity that they would normally audit.

- Internal Audit reports functionally to the CCHHS Board of Directors through its Audit and Compliance Committee and administratively to the Chief Executive Officer.
- Internal Audit periodically reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership as outlined in the section on Accountability.

Accountability

Internal Audit is accountable to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership to:

- Report significant issues related to the process for controlling the activities of the organization, including potential improvements to those processes, and provide information concerning such issues through resolution.
- Provide information periodically on the status and results of the annual audit plan and the sufficiency of internal audit resources.
- Coordinate with and provide oversight of other control and monitoring functions.

Audit Scope

The scope of the work of Internal Audit is to determine whether the network of risk management, control and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

- Risks are identified and managed.
- Interaction with various governance groups occurs as needed.
- Significant financial, managerial and operating information is accurate, reliable and timely.
- Employee's actions are in compliance with policies, standards, procedures and applicable laws and regulations.
- Resources are acquired economically, used efficiently, and adequately protected.
- Programs, plans and objectives are achieved.
- Quality and continuous improvement are fostered in control processes.
- Significant legislative or regulatory issues impacting the organization are recognized and addressed properly.

Responsibility

- Develop an annual audit plan using risk-based methodology, including any risk or control concerns expressed by management, and submit the plan to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership for approval.
- Implement the audit plan and any special requests by the CCHHS Board of Directors, its Audit and Compliance Committee, and CCHHS Senior Leadership and management.
- Maintain a professional audit staff capable of meeting the requirements of this Charter.
- Establish a quality assurance program whereby the director of internal audit assures the operations of internal audit.
- Perform consulting services in addition to assurance services. Consulting services are defined as "advisory and related client services activities, the nature and scope of which are agreed with the client and which are intended to add value and improve the organization's governance, risk management and control processes without the internal auditor assuming management responsibility." Examples include counsel, advice, facilitation, and training.
- Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations and control processes, coincident with their development, implementation and/or expansion.

- Issue periodic reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership summarizing results of internal audit activities.
- Inform the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership of emerging trends and successful practices in internal auditing.
- Provide the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership a list of internal audit measurement goals and results.
- Assist in the investigation of significant suspected fraudulent activities.
- Consider the scope of work of the external auditors and regulators for the purpose of providing optimal audit coverage at a reasonable cost.

Commissioner Jerry Butler
Audit and Compliance Committee Chair

Hill Hammock
Chairman of the Board

Dr. John Jay Shannon, MD
Chief Executive Officer

Tom Schroeder
Director of Internal Audit